kaiser commission on medicaid and the uninsured
KEY FACTS
THE HENRY J. KAISER FAMILY FOUNDATION

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MEDICAID AND MANAGED CARE

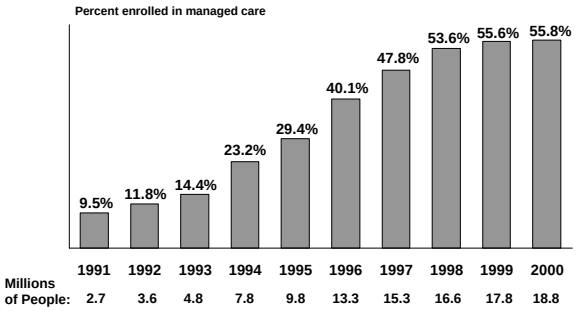
Medicaid provided health and long-term care coverage to nearly 44 million low-income Americans in 2001. As the nation's largest purchaser of health services for low-income families, Medicaid has increasingly relied on managed care to deliver services. Over half (56%) of Medicaid beneficiaries, predominately low-income children and their parents, now receive health care services through a broad array of managed care arrangements.

MEDICAID MANAGED CARE ENROLLMENT

Medicaid provided coverage to 18.8 million beneficiaries under managed care arrangements in 2000, nearly a seven-fold increase from 2.7 million in 1991 (Figure 1). Medicaid managed care enrollment has stabilized in recent years, following brisk growth in the early 1990s when many states first began moving their enrollees into managed care.

Figure 1

Growth in the Share of Medicaid Beneficiaries Enrolled in Managed Care, 1991-2000

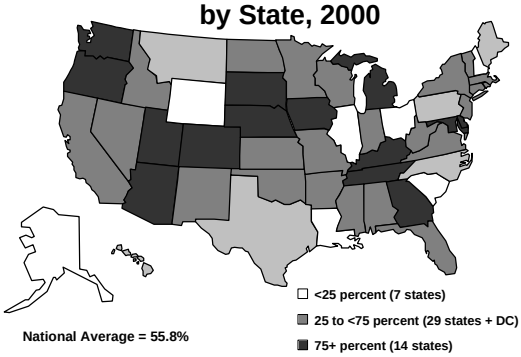


Note: Includes full-risk and PCCM arrangements.
SOURCE: CMS, 2001.

Today, all states (except AK and WY) have enrolled some portion of their Medicaid population in managed care. As of June 2000, 43 states and D.C. had more than one-quarter of their Medicaid population enrolled in managed care (Figure 2). Of these, 14 states had more than 75% of their Medicaid beneficiaries enrolled in managed care.

Figure 2

Medicaid Managed Care Enrollment, by State, 2000



Note: Includes full-risk and PCCM arrangements.
SOURCE: CMS, 2001.

STATE MANAGED CARE OPTIONS

States have long had the option to voluntarily enroll Medicaid beneficiaries in managed care plans, but now have broader authority to mandate enrollment. Thirty-one states and DC currently use 1915(b) waivers to implement mandatory managed care in part of the state or for certain categories of beneficiaries. Section 1115 waivers have been used to implement statewide mandatory managed care enrollment as part of comprehensive health care reform demonstrations. 19 states have active Section 1115 waivers (AR, AZ, CA, DE, HI, KY, MA, MD, MN, MO, NM, NY, OH, OK, OR, RI, TN, VT, WI).

The Balanced Budget Act (BBA) of 1997 gave states authority to mandate enrollment in MCOs for Medicaid beneficiaries without obtaining a federal waiver (except for special needs children, Medicare beneficiaries and Native Americans). Furthermore, the law permitted the establishment of Medicaid-only plans by eliminating the 75/25 rule, which required that 25% of a plan's enrollment be privately insured. The BBA also established certain managed care consumer protections for Medicaid beneficiaries. Finally, the law required states to develop and implement a quality assessment and improvement strategy and called for external independent review of MCO performance.

The consumer protection and quality assurance requirements in the BBA have yet to be implemented, however. In August 2001, the Centers for Medicare and Medicaid Services (CMS) delayed the implementation of a January 2001 final rule issued by the outgoing Clinton Administration. CMS released a revised rule that reduced some requirements placed on states but removed several protective safeguards for vulnerable enrollees. The comment period for this rule ended on October 19, 2001, and a final rule should be issued in the near future.

MODELS OF MEDICAID MANAGED CARE

Managed care is designed to improve access and reduce costs by eliminating inappropriate and unnecessary services and relying more heavily on primary care and coordination of care. State Medicaid agencies contract for health care services through a variety of managed care arrangements. The major Medicaid managed care models include:

- ***Risk-Based:*** Under the risk-based model, a managed care organization (MCO) is paid a fixed monthly fee per enrollee (capitation) and assumes some (partial-risk) or all (full-risk) of the financial risk for the delivery of a broad range of services. Some plans contract on a more limited basis (i.e., ambulatory care only). About four-fifths of Medicaid managed care enrollees receive services under this model.
- ***Fee-for-Service Primary Care Case Management (PCCM):*** Under the PCCM model, a provider, usually the patient's primary care physician, is responsible for acting as a "gatekeeper" to approve and monitor the provision of services to beneficiaries. These gatekeepers do not assume financial risk for the provision

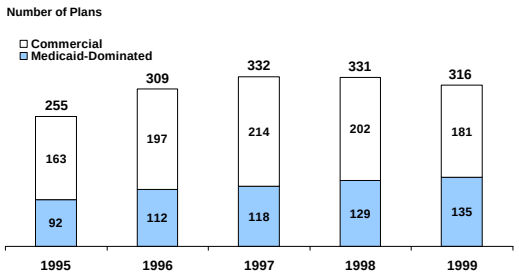
of services, and are paid a per-patient monthly case management fee. Thirty states used PCCM models to provide services to nearly one in five Medicaid managed care enrollees in 2000.

TRENDS IN MEDICAID MANAGED CARE

As of June 2000, 556 Medicaid managed care plans, primarily full-risk MCOs, were in operation. Although there was significant growth in the number of full-risk Medicaid plans in the mid-1990s, rising from 255 in 1995 to 332 in 1997, the total number of full-risk plans had dropped to 316 in 1999, reflecting a decline in commercial plan participation (Figure 3).

Figure 3

Participating Full-Risk Commercial and Medicaid-Dominated Plans, 1995-1999



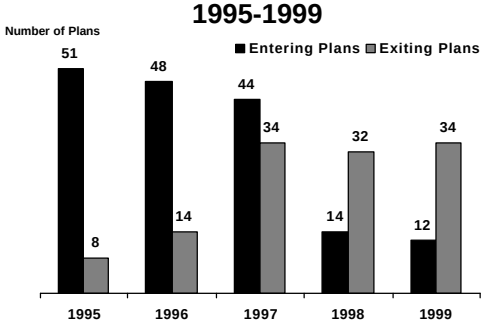
NOTE: Medicaid-Dominated Plans include those with Medicaid comprising 75% or more of total plan enrollment. Commercial plans include those with primarily private enrollment.
SOURCE: Mathematica Policy Research for The Kaiser Commission on Medicaid and the Uninsured, 2001.

In 1999 43% of Medicaid managed care enrollees were in fully capitated "Medicaid-dominated" plans, comprised of safety net providers, commercial plan subsidiaries, provider-sponsored plans, and others, up from 36% in 1997.

Recent analysis has shown that the number of commercial plans exiting the Medicaid market has increased and been consistently high in the late 1990s, while the number entering the market has fallen considerably (Figure 4).

Figure 4

Number of Commercial Plans Entering and Exiting State Medicaid Markets, 1995-1999



SOURCE: Mathematica Policy Research for the Kaiser Commission on Medicaid and the Uninsured, 2001.

Studies have documented that the adequacy of capitation rates and the stability of enrollment volume are key determinants in commercial plans' decisions to enter, exit, or remain in the Medicaid market.

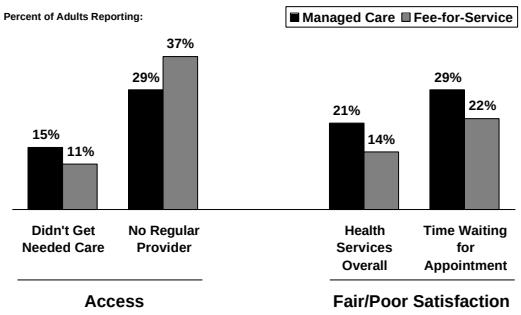
More research is needed on how participation by these plans affects access and quality of care. This will become increasingly important as more vulnerable beneficiaries, such as the disabled, enroll in Medicaid managed care. Roughly one in four non-elderly Medicaid enrollees with disabilities are in managed care, and the majority of these are in mandatory, capitated plans. While managed care is attractive because of its potential to reduce spending and better coordinate care, it may actually underserve this population if not carefully monitored.

ISSUES IN MEDICAID MANAGED CARE

Medicaid beneficiaries are economically disadvantaged, frequently reside in medically underserved areas, and often have more complex health and social needs than do higher-income Americans. Early evidence on the implementation of Medicaid managed care shows some improvement in access to a regular provider but more difficulties obtaining care and dissatisfaction with care for managed care enrollees compared to those in Medicaid fee for service (Figure 5).

Figure 5

Access and Satisfaction Problems for Medicaid Beneficiaries by Care Arrangement, 1995-1996



SOURCE: Based on an analysis of the Kaiser/Commonwealth Five-State Survey, Lillie-Blanton and Lyons, 1998.

Medicaid provider payment rates have historically been substantially below market rates, contributing to access problems. Capitation rates need to be sufficient to ensure that plans are able to adequately care for Medicaid enrollees. Medicaid-only MCOs, wholly dependent on Medicaid, do not have other payers to compensate for shortfalls, which can lead to instability in access to care for enrollees. One recent study demonstrated a more than twofold variation in capitation rates across all states, with most states paying rates significantly below Medicare rates.

Broadened use of managed care for low-income children and families is unlikely to accomplish large overall savings for Medicaid. Low-income children and adults account for only 25% of program spending; 65% of spending is for the elderly and the disabled. Enrollment of elderly and disabled populations into managed care is increasing, but is complicated by difficulties in setting appropriate capitation rates, limited plan experience in providing specialized services, and lack of systems to coordinate Medicare and Medicaid benefits for "dual eligibles."

The future success of Medicaid managed care depends on the adequacy of the capitation rates and the ability of state and federal government to monitor access and quality. The BBA provides new standards to assure plan capacity and enforce consumer protections. However, the development of access and quality performance standards for Medicaid MCOs and the measurement of compliance with those standards is evolving. Assuring access and quality of care in a managed care environment will require fiscally solvent plans, established provider networks, education of providers and beneficiaries about managed care, and awareness of the unique needs of the Medicaid population.

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